



National Audit Office



Clinical Governance Support Team

IMPROVING QUALITY AND SAFETY

Progress in Implementing Clinical Governance in
Primary Care: Key Questions for PCT Boards

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The NHS Clinical Governance Support Team's role is to provide information guidance and to assist organisations in understanding and successfully implementing clinical governance.

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A Guide for Board Members
prepared by the National Audit Office and
the NHS Clinical Governance Support Team



National Audit Office



Clinical Governance Support Team

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FOREWORD

The importance of quality and safety to patient care has been highlighted in a number of National Audit Office reports. This booklet draws on our first report examining progress with implementing clinical governance in primary care *Improving Quality and Safety – Progress in Implementing Clinical Governance in Primary Care: Lessons for the New Primary Care Trusts*. In the report we concluded, in discussion with the NHS Clinical Governance Support Team, that some further indication would be helpful of the key areas where Chief Executives and Boards might focus their efforts when looking at how to make further progress with the implementation of clinical governance in the new Primary Care Trusts.

We have therefore identified a number of high level questions and supporting facts that we believe are important for effective clinical governance. By addressing these, we hope to encourage discussions at Board level which in turn should help provide assurance to the Executive and the Board that their statutory duty of quality for Primary Care Trusts is being fulfilled.

John Bourn

Comptroller and Auditor General

I am delighted that the NHS Clinical Governance Support Team (NCGST) has been asked to cosponsor this important guide for PCT Board members.

Established in 1999, NCGST was set up to work with the NHS in implementing clinical governance and as a centre of expertise in clinical governance matters. In the past it has offered practical support through development programmes, such as the Board Development Programme, and by working directly with ‘challenged’ trusts.

This Guide builds on the extensive work carried out by the NCGST Board Team. It recognises the increased emphasis now being placed on safety and quality as part of clinical governance and the current realignment of regulation and clinical governance.

Primary Care Trusts have a major contribution to make in promoting safety and quality in health care. This Guide is intended to assist Chief Executives and their Board members in this important work.

Dr Damian Jenkinson

Acting Medical Director,

NHS Clinical Governance Support Team

WHY IMPLEMENTING CLINICAL GOVERNANCE IS IMPORTANT FOR QUALITY IN THE NHS

“ *The scope of the new quality programme which is emerging in the NHS is bold and broad-based. Underpinning this has been the concept of clinical governance – a unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect a change of culture in NHS organisations to one where:*

openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received. ”

Sir Liam Donaldson, Chief Medical Officer¹

“ *In my view, if properly developed and well resourced, clinical governance could provide the most effective means of achieving two important aims. First, it could enable PCTs to detect poorly performing or dysfunctional GPs on their lists. It could also help practices to discover any problems or weaknesses among their own number. Second, it could have the beneficial effect of helping doctors who are performing satisfactorily to do even better.* ”

Dame Janet Smith, fifth Shipman report²

¹ *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08*, Department of Health, 2004.

² *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, Shipman Inquiry, 2004.

“ *The NHS has one of the strongest and most transparent systems for quality in the world: clear national standards, strong local clinical governance arrangements (to assure and improve quality locally), robust inspections and rigorous patient safety arrangements. ... We will continue to give a high priority to clinical governance and patient safety. The programme of patient safety launched by the Chief Medical Officer’s report ‘An organisation with a memory’ is becoming integral to local services.* ”

Department of Health³

“ *Clinical governance is deeply embedded in some services but is largely lacking in others ... few Chief Executive Officers match the depth of their fear of missing budgetary and productivity targets with the strength of their passion to improve quality and safety of services for their consumers.* ”

Sir Liam Donaldson, Chief Medical Officer⁴

“ *For many, clinical governance is seen as the organisational conscience, and, at its most idealistic, the ‘beating heart’ of care. ... It encapsulates an organisation’s statutory responsibility for the delivery of safe, high quality patient care and it is the vehicle through which ... accountable performance is made explicit and visible.* ”

Professor Aidan Halligan, former Director of Clinical Governance for the NHS⁵

3 *Our health, our care, our say: a new direction for community services.* Department of Health, January 2006.

4 *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients.* A report by the Chief Medical Officer. July 2006.

5 *Clinical governance: assuring the sacred duty of trust to patients,* Professor Aidan Halligan, 2005.

ABOUT THIS GUIDE

1 The Health Acts of 1999 and 2003 set out a statutory 'duty of quality' for all providers of NHS services. At the local NHS level, this duty of quality is discharged largely through implementing clinical governance. Clinical governance, implemented effectively, can provide PCT Chief Executives with assurance that healthcare, whether provided directly or commissioned from other providers, is both safe and of good quality.

2 The concept of clinical governance was introduced in 1998 as the centre piece of the Government's ten year programme to improve continuously the overall standard of clinical care; reduce variations in outcomes of, and access to, services; and ensure that local decisions are based on the most up to date evidence of what is known to be effective. The key principles of clinical governance are: a coherent approach to quality improvement, clear lines of accountability for clinical quality systems and effective processes for identifying and managing risk and addressing poor performance. It involves putting in place the information, methods and systems to ensure good quality so that problems are identified early, analysed and action taken to avoid further repetition.

3 The National Audit Office report *Improving Quality and Safety - Progress in Implementing Clinical Governance in Primary Care: Lessons for the New Primary Care Trusts* (HC 100) assessed progress in implementing nine key components of clinical governance (see figure opposite) in PCTs prior to the 2006 reconfiguration. Drawing on a census of PCTs carried out in Autumn 2005, and on surveys of front-line staff (GPs, practice nurses and pharmacists) the National Audit Office report seeks to provide a comprehensive assessment of progress in implementing clinical governance in the 303 PCTs prior to their reconfiguration and reduction in number to 152 PCTs in October 2006.

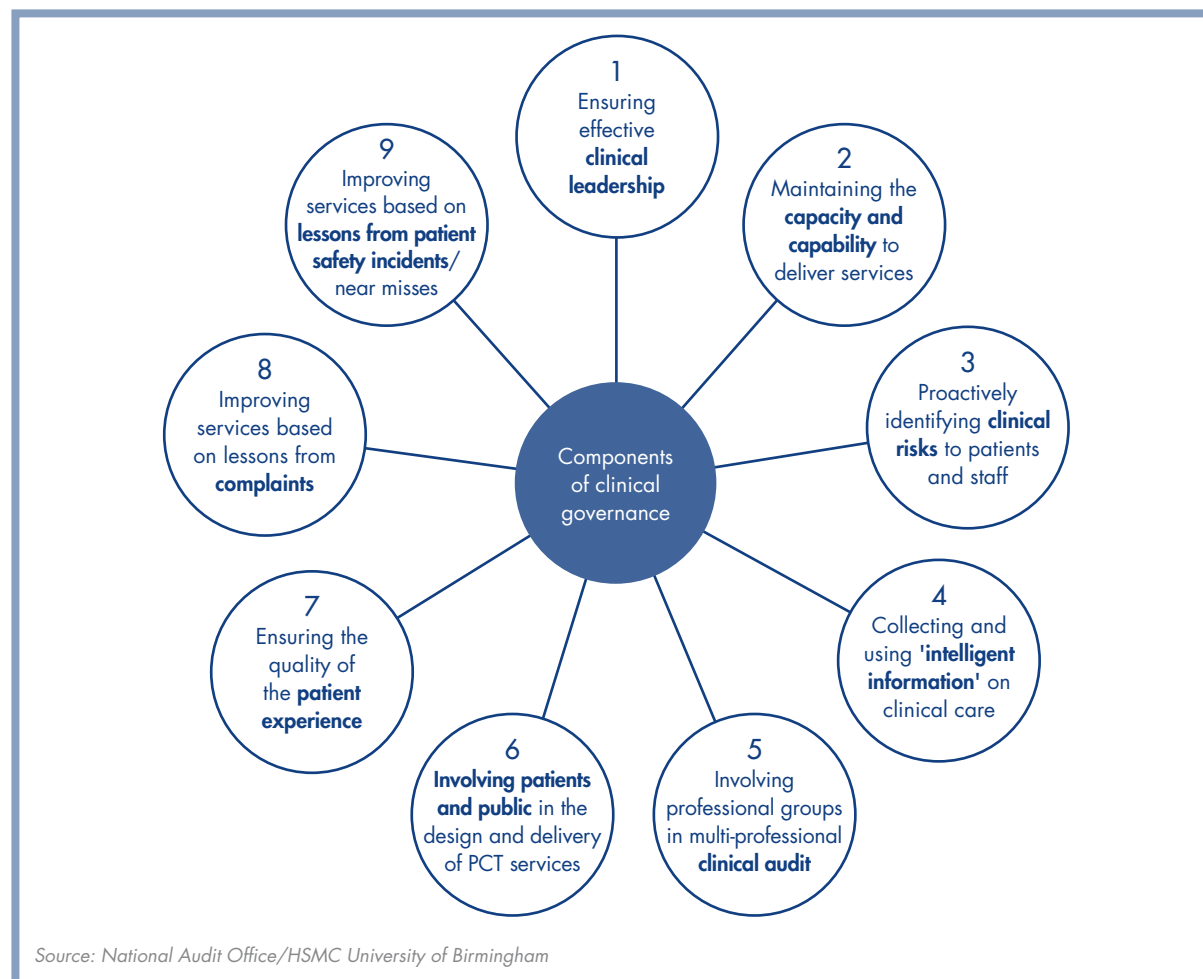
4 The aim of this Guide is to draw lessons from the findings of the National Audit Office report which highlight questions that Chief Executives and Boards of the newly established PCTs should ask themselves in order to assess their progress as they take forward the clinical governance agenda. It can be used alongside the individual feedback reports produced for each new PCT, by the Health Services Management Centre (HSMC) of the University of Birmingham on behalf of the National Audit Office. It should enable PCTs to benchmark their component PCTs' performance prior to the restructuring to help pinpoint the key risks and priorities for improvement. The feedback reports were derived from a census of PCTs carried out by HSMC (the results of this and other work underpinning the National Audit Office report can be found at www.nao.org.uk). This Guide builds on the National Audit Office report and work carried out with PCTs by the NHS Clinical Governance Support Team.

The key components of clinical governance in primary care

Clinical governance

The framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish

Source: A First Class Service – Quality in the new NHS. Department of Health, 1998, from Clinical governance and the drive for quality improvement in the new NHS in England, Scally & Donaldson, BMJ 1998; 317:61-65



1 STATUTORY RESPONSIBILITIES

All NHS trust Boards have a number of statutory responsibilities, with the Chief Executive as the named accountable officer for the trust.

QUESTIONS TO CONSIDER

- 1a** Is the PCT clear about its legal responsibilities in respect of quality and safety?
- 1b** Is the PCT clear about its other legal responsibilities in respect of clinical governance?

KEY FINDINGS FROM THE NAO REPORT

- The Health Acts of 1999 and 2003 set out a statutory 'duty of quality' for all providers of NHS services. At the local NHS level, this duty of quality is discharged largely through implementing clinical governance, which, if executed effectively, can provide PCT Chief Executives with assurance that healthcare, whether provided directly or commissioned from other providers, is both safe and of good quality.

KEY FACTS

The Health Act 1999 imposed for the first time a statutory duty of quality upon all trusts, with the Chief Executive as the accountable officer. Section 18 of the Act states:

- 'It is the duty of each Health Authority, Primary Care Trust and NHS trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare which it provides to individuals'.
- 'The reference in subsection (1) to healthcare which a body there mentioned provides to individuals includes healthcare which the body provides jointly with another person to individuals'.

Other statutory duties include :

- A duty of patient and public involvement (Health and Social Care Act 2001. S.11) – See Part 7 of this Guide.
- A duty of partnership and cooperation (Health Act 1999. S.31) – See Part 8 of this Guide.

In addition NHS trusts have a duty to maintain financial balance and ensure sound financial management.

Further information:

Health Act 1999. Section 18 – at www.opsi.gov.uk/acts

Health Act 1999. Section 31

Health and Social Care Act 2001. Section 11

The Code of Accountability for NHS Boards. Department of Health 1994

A First Class Service – Quality in the new NHS. Department of Health 1998

Governing the NHS: A guide for NHS Boards. Department of Health 2003

Department of Health website. www.dh.gov.uk

Direct Government website. www.direct.gov.uk

Healthcare Commission website. www.healthcarecommission.org.uk

2 STRUCTURES AND PROCESSES

Good clinical governance structures and processes are essential to provide assurance to the trust Board that safe, high quality services are being delivered to patients.

QUESTIONS TO CONSIDER

- 2a** Are robust clinical governance structures in place to offer the Board assurance on quality and safety on a regular basis:
- (i) in the PCT's directly provided services?
 - (ii) in the services provided by independent contractors?
 - (iii) in other PCTs and organisations with which the PCT works to deliver services?
- 2b** Is there linkage between the PCT's clinical governance systems and processes and its Declaration to the Healthcare Commission on compliance with *Standards for Better Health*?
- 2c** Does the PCT have processes for assuring them that, with respect to clinical services, national guidance (for example NICE, NSFs) is being implemented?

KEY FINDINGS FROM THE NAO REPORT

- At least 90 per cent of PCTs reported that they had structures and processes in place across the key components of clinical governance.
- Whilst almost all PCTs had a named lead member of staff for each component, the structures and processes were not always supported by written strategies about how to implement or sustain implementation of clinical governance.
- PCTs ranked in the lowest performance band for clinical governance were consistently least effective across all clinical governance activities whereas PCTs ranked in the highest performing band were strong across the board.
- Almost all PCTs have structures, processes and lead members of staff in place at PCT level, but these were not as extensive at sub-PCT level and across PCTs.

KEY FACTS

- Health Service Circular 1999/065 required all NHS trusts, as a minimum, to:

'... Identify lead clinicians for clinical governance and set up appropriate structures... for overseeing clinical governance within their organisations.'
- *Governing the NHS: A guide for NHS Boards (2003)* set out the governance requirements for NHS Boards and the systems for which they are responsible. The *Integrated Governance Handbook*, published in 2006, builds on the earlier document, highlighting the parallel activity in the public sector generally and overseas.
- In 2005, all healthcare organisations became responsible for ensuring that care delivered meets the Government's *Standards for Better Health*, in line with their statutory duty of quality. Clinical governance systems are the primary means of offering Boards the assurance that these standards are being met.
- *Health reform in England: update and commissioning framework (annex: the commissioning framework)*, offers further advice on 'governance'. (See Part 9).
- The *Standards for Better Health* specifically require healthcare organisations to 'ensure that principles of clinical governance are underpinning the work of every clinical team and every clinical service'. Standard D4(a).

Further information:

Detailed guidance on PCT structures, functions and governance is available on the DH website.

Clinical Governance in the new NHS HSC 1999/065

Governing the NHS: A guide for NHS Boards. Appointments Commission and Department of Health. 2003

Integrated Governance Handbook (2006) www.dh.gov.uk/governance

National Standards. Local Action: Health and social care standards planning framework 2005/06 - 2007/08

Further information on Standards for Better Health and the role of the Healthcare Commission can be found at www.healthcarecommission.org.uk

NHS Clinical Governance Support Team guidance at www.cgsupport.nhs.uk

3 ROLE OF BOARD AND PROFESSIONAL EXECUTIVE COMMITTEE (PEC)

It is important for PCTs to ensure that roles and responsibilities are clearly understood in the unique PCT tri-partite governance structure.

QUESTIONS TO CONSIDER

- 3a** Are the respective roles of the Board and PEC clearly defined and understood by all members of the two groups?
- 3b** Are the respective roles of the Board and PEC clearly defined and understood by all staff working for and with the PCT?
- 3c** Are the Board and PEC working effectively?
- 3d** Do non-executive directors, PEC and executive directors understand their respective roles in respect of quality and safety?
- 3e** Are health professionals actively engaged in the governance processes for improving quality and ensuring safety within the PCT?

KEY FINDINGS FROM THE NAO REPORT

- The Professional Executive Committee (PEC) is important for achieving clinical engagement in the PCT clinical governance agenda, yet PEC members are more sceptical about progress than Chief Executives and PCT Board members, and report lower perceived achievement with its implementation.
- PEC and Board members report that stronger performing PCTs undertake more clinical governance activity, and vice versa, and confirmed Chief Executives' views of the relative performance of the highest and lowest rated PCTs.

KEY FACTS

- *The good governance standard for public service*, developed by the Independent Commission for Good Governance in Public Services in 2004, states that:

'The governing body should set out clearly, in a public document, its approach to performing each of the functions of governance...The governing body should (also) set out a clear statement of the respective roles and responsibilities of the non-executive and the executive and its approach to putting this into practice.'

- With the establishment of the new PCTs, with their revised roles and responsibilities, it will be essential for Chairs and their Boards to review their responsibilities and the skills and competencies required of Board and PEC members.

- The PCT Fitness for Purpose Assessment, which all PCTs will have undergone by the end of 2006, includes a section on 'Board Capability' and a 'Chair and Board Tool' developed by the NHS Clinical Governance Support Team and the NHS Institute for Innovation and Improvement.
- The Department of Health has advised that the new PCTs will continue to have PECs and has issued a consultation document on their future role – *Fit to Lead* (November 2006). It is anticipated that new arrangements will come into effect from April 2007.
- The NHS Institute has made the development of PCT Boards one of its key priorities in 2006-07.

Further information:

The good governance standard for public service. The Independent Commission for Good Governance in Public Services. Office for Public Management and CIPFA. 2004 www.opm.co.uk/ICGGPS

PCT Fitness for Purpose Programme: PCT Assessment Tools. Department of Health. May 2006 www.dh.gov.uk/PublicationsAndStatistics

The Blue Book. NHS Institute for Innovation and Improvement. May-Oct 2006. www.institute.nhs.uk

Letter from Duncan Selbie to SHA Chief Executives regarding review of PECs – 7 September 2006

Standards for Better Health. Department of Health. 2004

Fit to Lead: a review of the Primary Care Trust Professional Executive Committee. Department of Health and NHS Alliance. November 2006

Details of resources for PEC members can be found at: www.networks.nhs.uk

4 LEADERSHIP AND CULTURE

Clear and consistent leadership, together with an open and fair culture are essential pre-requisites for the successful governance of the PCT.

QUESTIONS TO CONSIDER

- 4a** To what extent does the PCT demonstrate and encourage effective leadership?
- 4b** Does the PCT have processes for identifying and developing clinical leaders?
- 4c** Does the PCT have a culture that actively promotes the quality improvement and safety assurance of clinical services?
- 4d** Does the PCT promote a 'fair and just culture' around reporting adverse incidents and near misses?
- 4e** Does the PCT operate a 'no blame' culture?
- 4f** Does the PCT have effective whistle blowing policies and procedures that are understood by all staff?
- 4g** Has the PCT assessed the reporting authority of the Board?

KEY FINDINGS FROM THE NAO REPORT

- PCTs in band A (the strongest) were consistently the most effective in progressing clinical governance activities and had the highest coverage across their PCTs for clinical governance. One of the characteristics of the strongest PCTs is that they displayed effective clinical leadership.
- For the implementation of clinical governance to deliver tangible improvements, PCTs should put development programmes in place which emphasise the development of leadership skills for all PCT staff and for staff responsible for managing the commissioning and provision of services.
- Front-line staff reported a variety of day to day pressures that made the pursuit of clinical governance and quality goals difficult. Specific barriers were lack of time, financing and staff.
- PCTs should ensure there are effective systems in place for identifying and examining patient safety incidents, including the promotion of an open and fair culture and effective 'whistle blowing' procedures.

KEY FACTS

- The Government's health reform programme is actively encouraging the development of clinical leaders. One of its stated aims is 'Clinician and other staff leading change with greater freedom and support to focus on the quality of patient care...providing more scope for clinical leadership and engagement...' *Health reform in England: update and commissioning framework* – July 2006
- *Creating a Patient-led NHS*, published by the Department of Health in 2005, stated that 'The NHS needs a change of culture as well as systems to become truly patient-led'. It identifies greater support of front-line staff and clinical leadership as essential to this change.
- The *Standards for Better Health* third domain on Governance recognises that 'managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the healthcare organisation'.
- The National Leadership Network for Health and Social Care has been set up to promote and advise on a new leadership model for the NHS. Whilst the NHS Institute for Learning, Skills and Innovation has the responsibility for the development of leadership programmes.
- The NHS Clinical Governance Support Team has developed an online Primary Care Management Development Programme for practice managers in general medical and dental practices as well as in PCTs.

Further information:

The Strategic Leadership of Clinical Governance in PCTs: A learning resource for members of PCT Boards and PECs. NHS Clinical Governance Support Team. 2004

Making a difference: Engaging clinicians in PCTs. NHS Alliance and Clinical Governance Support Team. 2004 www.nhsalliance.org

Creating a Patient-led NHS: Delivering the NHS Improvement Plan. Department of Health. March 2005

Health Reform in England: update and commissioning framework. Department of Health. July 2006

The National Leadership Network for Health and Social Care. www.nationalleadershipnetwork.org

The NHS Institute offers a number of leadership programmes. www.institute.nhs.uk/Leadership

The Kings Fund offers a Board Leadership Programme for Chairs and non-executives in the NHS in London www.kingsfund.org.uk/leadership

NHS CGST Primary Care Management Development Programme: www.cgsupport.nhs.uk

The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England HC1143 2002-03 National Audit Office Report

5 INTELLIGENT INFORMATION

Good governance is underpinned by ‘intelligent information’ that offers the Board assurance that its strategic objectives are being met and that quality and safety are being maintained.

QUESTIONS TO CONSIDER

5a Does the PCT have ‘intelligent information’ that enables the Board to know whether the quality of services – commissioned and provided by the PCT – is continually being improved and safety assured?

5b Does the PCT have an agreed strategy to develop ‘intelligent information’ systems across the local health and social care economy?

5c Is the PCT working with local authority partners to map health inequalities and identify at risk populations?

5d Is the PCT identifying and learning from complaints and patient safety incidents and near misses across the range of PCT providers?

5e Has the PCT identified the costs arising from patient safety incidents (for example litigation costs)?

KEY FINDINGS FROM THE NAO REPORT

- Although almost all PCTs reported having structures and processes in place for collection of ‘intelligent information’ on clinical care, only half reported having a strategy for its usage.
- A lack of participation in national incident reporting systems means that opportunities for learning and development of solutions are being lost across much of primary care.
- Where GPs were involved in complaints reported to their PCT, just half of GP respondents were routinely informed of the outcome of such complaints by the PCT.
- Ninety five per cent of PCTs had structures and processes in place to involve professional groups in multidisciplinary audit, and 87 per cent said they had a written strategy in place. Just half of GPs surveyed, however, had an audit programme which included a multidisciplinary audit agreed with the PCT.

KEY FACTS

- *The Intelligent Board*, published in 2006 by the Appointments Commission, defined intelligent information as ‘information which enables the Board to ensure that users are receiving a high quality service and assure themselves that the organisation is complying with standards and other regulatory requirements’.
- *Our health, our care, our say* (January 2006) highlights the importance of information for commissioning and notes that the *Choosing Health* public health strategy will help commissioners to target health improvement.
- *Standards for Better Health* emphasise the need for effective information systems. Standard D6: ‘Healthcare organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning’.
- A major aim in *Health Reform in England* is for ‘extensive, comparable information on the quality and safety of care’.
- A National Audit Office study of patient safety, published in November 2005, found that the potential avoidable costs of patient safety incidents could be as much as £1 billion. The National Audit Office recommends that trusts should ensure that funding for managing and improving patient safety is related to the organisation’s risk register and that patient safety leads should develop business plans detailing opportunity costs of planned improvements in line with the National Patient Safety Agency format.

Further information

The Intelligent Board – NHS Appointments Commission – February 2006. www.appointments.org.uk

21st century IT Support for the NHS. Department of Health. 2002

Health Reform in England: update and commissioning framework. Department of Health. July 2006

National Standards Local Action – Health and Social Care Standards and Planning Framework 2005/06 – 2007/08 Department of Health. July 2004

A Safer Place for Patients: Learning to improve patient safety. National Audit Office. November 2005

National Patient Safety Agency and National Clinical Assessment Service websites at www.npsa.nhs.uk and www.ncas.npsa.uk

6 MAINTAINING GOOD PROFESSIONAL PRACTICE

Good patient care requires *all* staff to be competent, to keep their knowledge and skills up to date and to maintain good relationships with patients and colleagues.

QUESTIONS TO CONSIDER

- 6a** Does the PCT have assurance that all medical and non-medical professionals are 'fit to practice'?
- 6b** Are all clinical staff in the PCT being appraised annually and undertaking Continuing Professional Development?
- 6c** Does the PCT have an annual staff appraisal process for all staff that is based on an agreed work and development programme?
- 6d** Do all staff have Personal Development Plans which identify and address training needs?
- 6e** Are all professional staff involved in regular clinical audit?
- 6f** Are all staff trained in evidence-based practice?
- 6g** Is the PCT Board appraised of the duration and forecast costs of exclusions and suspensions and does it review these?

KEY FINDINGS FROM THE NAO REPORT

- PCTs rated the lack of training in evidence based practice as a relatively high risk to progress in improving quality and safety.
- Almost all GP respondents surveyed (96 per cent) received an annual (NHS) peer appraisal, but three per cent did not. Ninety per cent of GPs had had their requirements for Continuing Professional Development (CPD) identified, and most of these (79 per cent) felt that there were arrangements in place to meet their requirements. 18 per cent felt there were no arrangements in place.
- Eighty five per cent of nurse respondents surveyed received a performance appraisal on at least an annual basis. Three quarters of nurse respondents considered arrangements were in place to meet their CPD requirements. Half considered they had not received specific clinical governance training.

KEY FACTS

- *A First Class Service* (1998) put quality at the top of the Government's NHS agenda. It stated that 'Standards will be delivered locally through a new system of clinical governance, extended lifelong learning among staff and modernised professional self regulation.'
- The Chief Medical Officer's 2006 report *Good Doctors, Safer Patients* outlines proposals for strengthening regulation of doctors and improving their performance, including the standardisation and strengthening of the appraisal process, citing the work of the NHS Clinical Governance Support Team on the quality of annual appraisal.
- A Department review into the regulation of non-medical professionals was undertaken at the same time and a report – *The regulation of the non-medical health professions* – was released for consultation in July. It reviewed six areas of work, including continuing fitness to practice.
- In October 2006, the GMC issued its revised guidance to doctors – *Good Medical Practice*. It sets out guidance to all doctors on how they should conduct their professional practice, and to the public on what they should expect from doctors. It includes requirements for keeping knowledge and skills up to date; and maintaining and improving performance, including participating in appraisal and performance review and taking part in regular audit.
- The *Standards for Better Health* stress the need for 'an appropriately constituted workforce with appropriate skills' (Standard D5a), that 'clinicians continuously update skills and techniques relevant to their clinical work' (C5c), that 'clinicians participate in regular clinical audit and reviews of clinical service' (C5d), and that 'patients receive effective treatment and care that is delivered by healthcare professionals who make clinical decisions based on evidence-based practice' (D2d).

Further information

Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. Report by the Chief Medical Officer. July 2006. www.dh.gov.uk/PublicationsAndStatistics

The regulation of non-medical healthcare professionals. A review by the Department of Health. July 2006. www.dh.gov.uk/PublicationsAndStatistics

Good Medical Practice. General Medical Council. October 2006. www.gmc-uk.org

The NCGST NHS Appraisal for Doctors Group at www.appraisalsupport.nhs.uk offers wide ranging advice and support for doctors on appraisal

The DH website at www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining

7 PATIENT AND PUBLIC INVOLVEMENT (PPI)

Patient and Public Involvement in all aspects of the planning, development and delivery of care is essential to the establishment of a truly patient-led NHS.

QUESTIONS TO CONSIDER

- 7a** Does the PCT understand its statutory responsibilities in respect of PPI?
- 7b** Does the PCT have clear criteria for the establishment and effective working of user and carer groups?
- 7c** Are service users and carers involved in the development of services?
- 7d** Is the PCT offering and enabling patients to make choices?
- 7e** Is the PCT ensuring that its primary care contractors are engaging with patients and the public, and supporting them to do so where required?
- 7f** Does the PCT have appropriate information on patients' satisfaction with their experience of services?

KEY FINDINGS FROM THE NAO REPORT

- PCTs have structures and processes for patient and public involvement in place, but patient and public involvement is one of the least well developed components of clinical governance.
- PCTs rated a lack of involvement of service users in service development as one of the higher risks to progress in improving quality and safety compared to other aspects of clinical governance.
- In giving a commitment to allow patient choice and to give patients a real voice in the design of services under the NHS Reform agenda, patients' expectations have been raised and as yet PCTs are unable to meet these expectations.

KEY FACTS

- Section 11 of the Health and Social Care Act 2001 requires PCTs to involve local communities in the planning, development and delivery of services.
- *Creating a Patient-led NHS (2005)* takes this duty further: 'The NHS now has the capacity and the capability to move on from being an organisation which simply delivers services to people, to being one which is totally patient-led – responding to their needs and wishes. Every aspect of the new system is designed to create a service which is patient-led....'
- *A stronger local voice*, (Department of Health July 2006) proposed a framework for involving patients and the public in local health and social care developments including the establishment of local involvement networks (LINKs), a new duty on commissioners to respond to what patients and the public have said, and a stronger user voice in regulation.
- *Health reform in England; update and next steps* identifies a stronger voice for patients and greater choice as a key aspect of the NHS demand side reforms.
- The NHS Centre for Involvement, was established in May 2006, to help 'create services that are directly shaped by the views of patients and the public'.
- The *Standards for Better Health* are clear about patient and public involvement. Standard C17 states that healthcare organisations must ensure that 'The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services'.
- Whilst Standard D11 requires that health care organisations plan and deliver healthcare which 'reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice' (D11a); and 'maximises patient choice.' (D11b).

Further information

The Health and Social Care Act 2001. Section 11. www.dh.gov.uk/PolicyAndGuidance

Creating a Patient-led NHS. Department of Health. March 2005

A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services Department of Health. July 2006

Health reform in England: update and next steps. Department of Health. December 2005

Patient choice: A practice training toolkit. NHS Alliance and Dr Foster Intelligence. 2006. www.patientopinion.org.uk and www.drfoosterintelligence.co.uk

The NHS Centre for Involvement www2.warwick.ac.uk/PPICentre

8 PARTNERSHIP ARRANGEMENTS

These are key to the provision of seamless services for patients and their carers.

QUESTIONS TO CONSIDER

- 8a** Is the PCT addressing its statutory duty of partnership and collaboration?
- 8b** Is the PCT building and sustaining strategic partnerships with its local authorities and other partner organisations?
- 8c** Does the PCT have robust and constructive working relationships with all its providers in the NHS and independent sectors?
- 8d** Does the PCT have robust and constructive working relationships with its primary care contractors?
- 8e** Is the PCT working jointly with local health and social care agencies on clinical governance issues?

KEY FINDINGS FROM THE NAO REPORT

- Clinical governance links between PCTs and independent contractors are undeveloped. Whilst independent contractors such as GPs and pharmacists have processes and structures for clinical governance in place, these are not as extensive as at PCT level.
- Contractors felt that they received only limited support from the PCT in helping them embed clinical governance.
- PCTs' level of engagement and collaboration with voluntary organisations that support patients has generally been low. The 14 voluntary groups the National Audit Office surveyed agreed unanimously that PCTs needed to engage more effectively with them.
- These voluntary groups also considered that collaboration was rarely instigated by the PCT, although some PCTs collaborate with voluntary groups as they recognise that the services and specialist information voluntary groups offer can complement NHS services.

KEY FACTS

- Section 31 of the 1999 Health Act placed a new statutory duty of partnership and cooperation on NHS trusts. It created a new duty of cooperation within the NHS and extended this duty to include cooperation between NHS bodies and local authorities.
- This duty has been strengthened with the latest NHS reforms. *Our health, our care, our say: a new direction for community services*, the government White Paper on improved partnership working between health and social care, pledged to ensure that health and social care commissioners work together to understand health and social inequalities as well as better integration between the NHS and social care workers: 'A better integrated workforce – designed around the needs of people who use services and supported by common education frameworks and rewards – can deliver more personalised care, more effectively'.
- The PCT Fitness for Purpose Programme PCT Assessment Tool asks specific questions on external relationships in the section on 'Relationship Management'.

Further information

Health Act 1999. Section 31.
[www.dh.gov.uk/
PolicyAndGuidance](http://www.dh.gov.uk/PolicyAndGuidance)

*Our health, our care, our say:
a new direction for community
services.* Department of Health.
January 2006

*PCT Fitness for Purpose
Programme: PCT Assessment Tools.*
Department of Health. May 2006.

9 COMMISSIONING FOR QUALITY AND SAFETY

Commissioning will be essential to ensure enhanced quality services for patients whilst securing best value and choice.

QUESTIONS TO CONSIDER

- 9a** Is the PCT ensuring that commissioning arrangements take account of clinical risk?
- 9b** Does the PCT have robust clinical governance systems and arrangements in place for practice based commissioning (PBC)?
- 9c** Is the PCT commissioning for quality?
- 9d** Does the PCT have the right structures and indicators to ensure quality is built into commissioning arrangements?
- 9e** Is the PCT benchmarking commissioning against other organisations?
- 9f** Is the PCT benchmarking provision against other PCTs?
- 9g** Does the PCT have processes in place for ensuring that providers from which services are commissioned have satisfactory clinical governance arrangements in place?
- 9h** Is the PCT benchmarking with other key clinical governance initiatives?

KEY FINDINGS FROM THE NAO REPORT

- SHAs expressed concerns about readiness for commissioning in their areas. For instance they thought it would be particularly important for PCTs to adopt the right structures and indicators to ensure quality was built into commissioning arrangements.
- The aspects of poorest coverage in PCTs and lowest perceived effectiveness are those concerned with commissioning for quality.
- PCTs should benchmark skills, so that benchmarking of commissioning can be undertaken against other PCTs and of provision against other agencies.

KEY FACTS

- Following the publication of *Commissioning a Patient-led NHS in July 2005, Health reform in England: update and next steps* outlined the way in which the new system of practice based commissioning (PBC) is intended to drive the NHS Reform agenda. PCTs are required to ensure that robust governance arrangements, including those for clinical governance, are in place for PBC.
- *Our health, our care, our say* (January 2006), confirms the Government's commitment to joint commissioning, promising guidance on the commissioning of 'health and wellbeing' by the end of 2006 and synchronised performance management systems to ensure good joint commissioning by 2008.
- *Health reform in England: update and commissioning framework* (July 2006), provides a further update on the reforms as well as detailed guidance on some elements of commissioning activity, including a section for consultation on governance and accountability (Appendix D of the commissioning framework annex).
- It states that 'As statutory bodies, PCT Boards are responsible for securing the best possible services for their population, within their allocated budget. PCTs cannot hand over accountability for the commissioning function to others.'
- NICE (the National Institute for Health and Clinical Excellence) is to publish commissioning guides designed to assist in the commissioning of evidence-based care for patients, including mechanisms for quality and corporate assurance.
- The NHS Primary Care Contracting Team has been established to support trusts with commissioning and contracting responsibilities. The team offers specialist information, intelligence and training and development.
- The Improvement Foundation (incorporating the National Primary Care Development Team) provides support and development opportunities for all involved in PBC.

Further information:

Commissioning a Patient-led NHS. Sir Nigel Crisp letter to Chief Executive and PEC Chairs. 28 July 2005.

Our health, our care, our say: a new direction for community services. January 2006. Cm 6737

Health reform in England: update and next steps. Department of Health. December 2005

Health reform in England: update and commissioning framework. Department of Health. July 2006

PCT Fitness for Purpose Programme: commissioning diagnostic toolkit. Department of Health. May 2006

NICE guides on commissioning are available at www.nice.org.uk

NHS Primary Care Contracting Team: www.primarycarecontracting.nhs.uk

Further information on commissioning is available on the Department of Health website at www.dh.gov.uk/PolicyAndGuidance/OrganisationalPolicy/Commissioning

The Improvement Foundation: www.improvementfoundation.org

10 INTEGRATED GOVERNANCE

Integrated governance will enable the Board to assure itself that it is meeting *all* its legal and statutory responsibilities as well as its clinical and quality objectives.

QUESTIONS TO CONSIDER

10a Has the PCT aligned its clinical governance systems with other governance systems within the PCT so that they complement each other rather than overlapping?

10b Has the PCT reviewed and refined its committee structures to support an integrated system?

KEY FINDINGS FROM THE NAO REPORT

- The key features of those PCTs that can demonstrate consistent improvements in quality include effective clinical leadership, maintaining the capacity to deliver services, ensuring the quality of the patient experience and improving services based on lessons from complaints and patient safety incidents.
- PCTs ranked in the lowest performance band for clinical governance were consistently least effective across all clinical governance activities whereas PCTs ranked in the highest performing band were strong across the board.
- PCTs in the highest band were found generally to perform better when compared to a range of other performance indicators, such as staff survey results, number of complaints received, Healthcare Commission ratings, and GP vacancy levels.

KEY FACTS

- Integrated governance is defined as 'systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'. It is not intended to replace clinical governance, but rather to place it in the mainstream of all planning, decision-making and monitoring activity undertaken by the trust Board.
- *Health reform in England* (December 2005), confirmed that 'good clinical governance will remain a high priority' in the NHS. The Operating framework for 2006-07 also stated 'NHS organisations are expected to place a strong emphasis on the quality and safety of care, ensuring that local governance arrangements are strong...'
- In its guidance to the new PCTs in August 2006, the Department of Health went further, stating:
 - 'PCT Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance...Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives, resulting in a more cost effective service and more efficient processes.'
 - The *Standards for Better Health* require that 'Integrated governance arrangements representing best practice are in place in all healthcare organisations and across all health communities and clinical networks'. (Standard D3)
 - Comprehensive guidance on Integrated Governance is contained in *The Integrated Governance Handbook*, produced by NCGST and published by the Department of Health in February 2006. This is intended to be the first in a series of publications outlining the way to achieve 'optimal governance'.

Further information

Health reform in England: update and next steps. Department of Health. December 2005

Primary Care Trust – Model Corporate Governance Documents. Department of Health. August 2006

Integrated Governance Handbook: a handbook for executives and non-executives in healthcare organisations. Department of Health. February 2006

NCGST has produced a further set of questions, or challenges, for Board members entitled *Board Assurance Prompts or BAPS*. These are available at www.cgsupport.nhs.uk/Resources/Board_Assurance_Prompts.asp

Further advice on this guide can be obtained by contacting the following people:

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